in the following manner: The profile of the nose was normal, but after dividing the vomer and pushing back the premaxillary bone into the gap in the alveolar arch, a marked deformity was produced from the pull on the tip of the nose. The stunted median portion of the lip was then separated from the premaxillary bone. An incision was made directly upward as far as possible through the mucous membrane, perichondrium, cartilaginous septum, and perpendicular plate of the ethmoid bone. The bleeding was slight. There remained along the bridge of the nose a broad piece of bone and cartilage, which maintained the existing profile of the nose, because it did not accompany the backward displacement of the premaxillary bone. In order that the mucoperiosteum of the nasal wall may not resist this backward movement it is first divided. The vomer behind the premaxillary bone is then divided subperiosteally and in a V-shape before pushing the premaxillary bone back to its proper place. The nourishment of the remaining portion of the vomer is aided by making this V-shaped excision subperiosteally, the nasopalatine artery being thus preserved. After the premaxillary bone is placed in its proper place it is fixed in position by the repair of the harelip. This should provide two short lateral incisions in the cheek, according to the method of Mirault for mobilizing the lateral flaps. The median piece of the lip which has been separated upward is employed to complete the normal septum. The result of the operation was good. There was absent the flattening due to extirpation of the premaxillary bone, which now filled the defect in the alveolar arch. The disturbance in the development in the upper jaw when the premaxillary bone is removed was not seen. The nasal septum was high, the tip of the nose not drawn in, and the profile of the nose was good.

Myonephropexy.—JIANO (*Ann. d. mal. d. org. gén.-urin.*, 1911, i, 981) did the following operation for a movable kidney on the right side in a woman, aged fifty years. The patient was placed in the left lateral decubitus, with a cushion under the flank to render the right side prominent. The left lower extremity was flexed upon the abdomen and the right placed in extension. Spinal anesthesia was employed. An incision was made along the external border of the erector spinæ muscle, beginning at the lower border of the tenth rib and ending 2 cm. above the iliac crest. The incised skin was dissected on both sides from the underlying muscles for about 5 cm. An incision was then made through the first plane of muscles formed by the latissimus dorsi and the small inferior serratus. On the internal side of the wound these muscles were dissected up from the erector spinæ. From the latter were cut two muscle strips, one short and one long, and both one to two centimeters wide. Then the other muscle layers were divided and the kidney exposed. The latter was brought to the surface and decapsulated over an area of 2 cm. The isolated muscle strips were passed transversely under the kidney, as a support for the latter. The distance between the two muscle strips was from 3 to 4 cm., which allowed for the hilum of the kidney. A catgut suture was passed through the free end of each muscle strip. In the upper part of the wound, about 5 cm. from the external edge, the muscle flap is penetrated by a Reverdin needle from without inward. The needle is then threaded

with one end of the catgut suture of the first muscle strip and the suture drawn through the muscle flap. The other end is drawn through in a similar manner, a half centimeter away. Both ends being tied together, the first muscle strip is fixed, thus supporting the superior pole of the kidney. Three or four centimeters lower, the other muscle strip is fixed in a similar manner. A transverse bridge is thus formed for the support of the whole kidney. To prevent movement of the kidney, the edges of the stripped-up capsule are fixed on each side to the muscle strips. The abdominal wall is then closed with sutures. Eleven days after the operation the patient left the hospital completely cured. Jiano concludes that myonephropexy is an operation easy of performance and absolutely benign. It assures a good fixation of the kidney without any disturbance in the escape of urine. It dispenses with all inconvenient products owing to the permanence of the supports—pain, suppuration, fistulæ, and the formation of sclerotic tissue in the renal parenchyma.

Concerning a Case of Invagination of the Ileum Cured by Resection: A Contribution to the Treatment of Intussusception.—HAAGN (*Deut. Zschr. f. Chir.*, 1911, 142) says that the general tendency is to regard total resection as indicated only when all other methods of treatment have failed. He reports a case in which, after exposure of the intussusception which involved the ileum about a hand's breadth from the cecum, it was found impossible to reduce the invagination. It was resected and the bowel ends united by circular suture. The patient recovered and was discharged one month after the operation. Three months later the patient was again examined and found well, and six months pregnant. She was delivered successfully. Leichenstern found that in 479 cases of invagination spontaneous reduction of the invagination occurred in 15 cases; also in 15.6 per cent. of the cases of invagination of the ileum, with a mortality of 42.6 per cent. We cannot, therefore, rely upon this method of treatment. Haagn agrees with Rydigier in the following conclusions on the treatment of intussusception: In acute invagination operation should be performed as soon as possible after properly employed non-operative measures have been tried without success. When a laparotomy has been done, disinvagination is to be preferred when it can be carried out without special difficulty. If the intestinal wall at any place in the area of invagination is suspicious, a strip of iodoform gauze should be introduced to this place or the affected area excluded from the abdominal cavity. Resection of the whole invagination is indicated when the intestinal wall shows marked changes or threatens perforation. The employment of an artificial anus, or entero-anastomosis, is to be condemned. Haagn believes that in ileocecal and colon invagination, when disinvagination has been difficult and the serous surface of the intussuscipiens is intact, the intussusceptum may be resected. In case, however, the invagination is only a short one, a total resection should be done, because of the better prospects of a radical cure, although one should also take into account the general condition and age of the patient. If very short, unless reduced with very little difficulty, resection is to be preferred to all other methods. But even when the invagination is easily reduced, a secondary resection must be kept in mind, since it is the only sure means for the prevention of a recurrence.